SECTION V:

INDEPENDENT AUDITORS' REPORT ON DEPARTMENT'S FINANCIAL STATEMENTS AND MANAGEMENT RESPONSE TO THE AUDIT

DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Washington, D.C. 20201

FEB 29 2000

To: The Secretary
Through: DS _____
COS ____
ES _____

From: Inspector General

Subject: Report on the Financial Statement Audit of the Department of Health and Human Services for Fiscal Year 1999 (CIN: A-17-99-00002)

PURPOSE

Our purpose is to provide you with our audit report on the Department's Consolidated/Combined Financial Statements for Fiscal Year (FY) 1999. This audit is required by the Government Management Reform Act of 1994.

The attached report reiterates several problems reported at the Health Care Financing Administration (HCFA) and highlights systemic problems noted during eight other operating divisions' financial statement audits.

Following is a summary of the major issues discussed in the Departmentwide audit report.

INFORMATION TEXT

In our opinion, the Department of Health and Human Services (HHS) FY 1999 financial statements present fairly, in all material respects, the HHS financial position at September 30, 1999; the consolidated net costs and changes in net position; and the combined budgetary resources and financing for the year then ended in accordance with generally accepted accounting principles.

As discussed in our report on internal controls, financial systems and reporting continue to be a problem. Although improved from FY 1998, draft financial statements and notes for all divisions, as well as the Departmentwide statements, were again provided late in the audit process. In some instances, adjustments to operating division financial statements were still being made in February 2000, 5 months after the fiscal year ended. We again report HHS' need for a fully functioning, integrated financial system. We also once again point out the need to conduct periodic reconciliations and account analyses throughout the year.

Our report on internal controls notes two other internal control weaknesses that we consider to be material under standards established by the American Institute of Certified Public Accountants and Office of Management and Budget Bulletin 98-08, as amended.

1. Significant improvements are still needed in Medicare contractors' development, collection, and reporting of receivable activity.

2. The HCFA central office and HCFA contractors continue to have material internal control weaknesses in electronic data processing controls relating to security access and application development and change controls.

Material weaknesses are those problems that are systemic across a number of operating divisions, as well as significant dollar issues affecting only one division. These weaknesses are synopsized in this report and are fully described in the individual financial statement audit reports which we released separately.

We are grateful for the cooperation the Department has extended to us in performing this audit. If you have any questions, please contact me or have your staff contact Joseph E. Vengrin, Assistant Inspector General for Audit Operations and Financial Statement Activities, at (202) 619-1157.

June Gibbs Brown

Attachment

cc:
John J. Callahan
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George H. Strader
Deputy Assistant Secretary, Finance

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REPORT ON THE FINANCIAL STATEMENT AUDIT OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR FISCAL YEAR 1999

JUNE GIBBS BROWN
Inspector General

FEBRUARY 2000
A-17-99-00002

Office of Inspector General

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The OIG's office of Audit Services (OAS) provides all auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations in order to reduce waste, abuse, and mismanagement and to promote economy and efficiency throughout the Department.

Office of Evaluation and Inspections

The OIG's Office of Evaluation and Inspections (OEI) conducts short-term management and program evaluations (called inspections) that focus on issues of concern to the Department, the Congress, and the public. The findings and recommendations contained in the inspections reports generate rapid, accurate, and up-to-date information on the efficiency, vulnerability, and effectiveness of departmental programs.

Office of Investigations

The OIG's office of Investigations (OI) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions, or civil monetary penalties. The OI also oversees State Medicaid program.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions and HHS programs and operations and providing all legal support in OIG's internal operations. The OCIG imposes program exclusions and civil monetary penalties on health care providers and litigates those actions within the Department. The OCIG also represents OIG in the global settlement of cases arising under the Civil False Claims Act, develops and monitors corporate integrity agreements, develops model compliance plans, renders advisory opinions on OIG sanctions to the health care community, and issues fraud alerts and other industry guidance.

INDEPENDENT AUDITOR'S REPORT

INSPECTOR GENERAL'S REPORT ON THE DEPARTMENT OF HEALTH AND HUMAN SERVICES CONSOLIDATED/COMBINED FINANCIAL STATEMENTS FOR FISCAL YEAR 1999

To: The Secretary of Health
and Human Services

We have audited the accompanying consolidated balance sheet of the Department of Health and Human Services (HHS) as of September 30, 1999; the related consolidated statements of net cost and changes in net position; and the combined statements of budgetary resources and financing (principal financial statements) for the fiscal year (FY) then ended. These financial statements are the responsibility of HHS management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with generally accepted auditing standards; *Government Auditing Standards* issued by the Comptroller General of the United States; and Office of Management and Budget (OMB) Bulletin 98-08, *Audit Requirements for Federal Financial Statements,* as amended. These standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

In our opinion, the principal financial statements referred to above present fairly, in all material respects, the financial position of HHS at September 30, 1999; the consolidated net costs and changes in net position; and the combined budgetary resources and financing for the year then ended in accordance with generally accepted accounting principles.

Our audit was conducted for the purpose of forming an opinion on the principal financial statements referred to in the first paragraph. The information presented in the overview of HHS and the supplemental information of HHS is not a required part of the principal financial statements but is supplementary information required by OMB Bulletin 97-01, *Form and Content of Agency Financial Statements*. Such information, including trust fund projections, has not been subjected to the auditing procedures applied in the audit of the principal financial statements; accordingly, we express no opinion on it.

REPORT ON INTERNAL CONTROLS

We conducted our audit in accordance with generally accepted auditing standards; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and OMB Bulletin 98-08, *Audit Requirements for Federal Financial Statements,* as amended.

In planning and performing our audit, we considered the HHS internal controls over financial reporting by obtaining an understanding of internal controls, determining whether these controls had been placed in operation, assessing control risk, and performing tests of controls in order to determine our auditing procedures for the purpose of expressing our opinion on the financial statements. We limited our internal control testing to those controls necessary to achieve the objectives described in OMB Bulletin 98-08, as amended. We did not test all internal controls relevant to operating objectives as broadly defined by the Federal Managers' Financial Integrity Act of 1982, such as those controls relevant to ensuring efficient operations. The objective of our audit was not to provide assurance on internal control. Consequently, we do not provide an opinion on internal control.

The HHS management is responsible for establishing and maintaining internal controls. In fulfilling this responsibility, estimates and judgments by management are required to assess the expected benefits and related costs of internal control policies and procedures. The objectives of internal controls are to provide management with reasonable, but not absolute, assurance that (1) assets are safeguarded against loss from unauthorized use or disposition, (2) transactions are executed in accordance with management's authorization and recorded properly to permit the preparation of financial statements in accordance with generally accepted accounting principles, and (3) data that support reported performance measures are properly recorded and accounted for to permit preparation of reliable and complete performance information.

Our consideration of internal controls over financial reporting would not necessarily disclose all matters in these controls that might be reportable conditions. Under standards issued by the American Institute of Certified Public Accountants, reportable conditions are matters coming to our attention relating to significant deficiencies in the design or operation of internal controls that, in our judgment, could adversely affect the HHS ability to record, process, summarize, and report financial data consistent with the assertions by management in the financial statements. Material weaknesses are reportable conditions in which the design or operation of one or more of the internal control components does not reduce to a relatively low level the risk that misstatements in amounts material to the financial statements may occur and not be detected within a timely period by employees in the normal course of performing their duties. Because of inherent limitations in internal controls, misstatements, losses, or noncompliance may nevertheless occur and not be detected. Also, projections of any evaluation of internal controls

may become inadequate because of changes in conditions, or the degree of compliance with policies or procedures may deteriorate. However, we noted certain matters discussed below involving internal controls and their operation that we consider to be reportable conditions and material weaknesses.

In addition, we considered the HHS internal controls over Required Supplementary Stewardship Information by obtaining an understanding of the internal controls, determining whether the controls had been placed in operation, assessing control risk, and performing tests of controls as required by OMB Bulletin 98-08, as amended. Our procedures were not intended to provide assurance on these controls; accordingly, we do not provide an opinion on them.

Finally, with respect to internal controls related to performance measures reported in the *FY 1999 HHS Accountability Report*, we obtained an understanding of the design of significant internal controls related to the existence and completeness assertions, as required by OMB Bulletin 98-08, as amended. Our procedures were not designed to provide assurance on performance measure controls, and we do not provide an opinion on them.

Using the criteria and standards established by the American Institute of Certified Public Accountants and OMB Bulletin 98-08, as amended, we identified three internal control weaknesses that we consider to be material and four reportable conditions, as follows:

INTERNAL CONTROL WEAKNESSES*

*All repeat conditions except HCFA regional office oversight of Medicare.

MATERIAL WEAKNESSES

1. Financial Systems and Reporting (Repeat Condition)

Since passage of the Chief Financial Officers Act, as amended by the Government Management Reform Act of 1994, agencies have prepared financial statements for audit by the Inspectors General. The act emphasized production of reliable financial statements; consequently, HHS worked diligently to prepare statements capable of receiving an unqualified audit opinion. With this year's audit, HHS has achieved the important milestone of an unqualified, or "clean," opinion.

A clean audit opinion, however, assures financial statement users only that the information is reliable and fairly presented. It provides no assurance about the effectiveness and efficiency of financial systems used to prepare the statements and to produce other information for management use. Two key directives address Federal agency requirements concerning these systems. The OMB Circular A-123, *Management Accountability and Control*, specifies the management control standards agencies must follow. Among the standards is the requirement that transactions be promptly recorded, properly classified, and correctly accounted for to prepare timely accounts and reliable financial and other reports. The OMB Circular A-127, *Financial Management Systems*, specifies the system requirements agencies must follow to meet management control standards. The term "system" includes manual processes, such as reconciliations and analyses, and automated processes.

In our opinion, the Department still has serious problems with controls over financial systems and reporting. The process used to prepare financial statements required numerous manual account adjustments before reliable, accurate statements were produced. This process caused delays in preparing the statements, increased the risk of material misstatements, and limited the resources available for financial analyses. Because the operating divisions did not conduct such analyses and account reconciliations throughout the year, management had little assurance of detecting accounting aberrations and obtaining reliable financial information.

The extent and magnitude of account adjustments required at yearend demonstrate that the systems in place during FY 1999 were not operating efficiently or effectively. The need for these manual adjustments increased resource requirements. However, even with additional resources, many operating divisions were not able to produce auditable information until 5 months after the fiscal year ended. For example:

> The financial statement preparation process required many yearend manual adjustments, which caused delays and increased the risk of material errors.

- **Health Care Financing Administration (HCFA).** The Department's largest operating division with $299 billion in net outlays, HCFA issued the first FY 1999 financial statements in mid-December 1999 and then made billions of dollars in adjustments to payables and receivables before producing final, auditable financial statements in late January 2000. Oversight by the HCFA central and regional offices was not adequate to provide reasonable assurance of promptly detecting material errors in Medicare contractor financial data.

- **Administration for Children and Families (ACF).** The ACF, the second largest operating division with net budget outlays of about $34 billion, made billions of dollars in adjustments to current and prior-year accounts before preparing a complete set of reliable financial statements in January 2000. Although some adjustments related to those used to prepare the FY 1998 financial statements, they had not been posted to the general ledger as of September 30, 1999. The volume of these adjustments and the time it took to prepare the statements indicate that the level of analysis was insufficient to meet current OMB reporting requirements. Had the adjustments not been made, the condition of the financial statements, particularly the statement of budgetary resources, the statement of financing, and the statement of changes in net position, would have precluded expression of an audit opinion. Details follow:

  - The ACF's budgetary accounts needed numerous adjustments totaling over $100 billion because thousands of transactions had been incorrectly recorded and accounts had not been analyzed for several years to correct such errors. Accumulated errors in the account balances therefore required one-time "catch up" adjustments. In addition, certain amounts shown on the first draft of the statement of budgetary resources changed by over $500 million from the amounts on the final statement.

  - The ACF did not reconcile its net position accounts with operating and budgetary activity in its general ledger during the year. As a result, ACF was again unable to provide complete details or an analysis of the composition of the net position balance at September 30, 1999. Problems in reconciling net position accounts arose because a significant number of adjustments were recorded only during the financial statement preparation process. Those made while preparing the financial statements had an absolute value of over $8 billion, were made outside the general ledger, and included entries related to prior-year activity. We also noted that $87 million of net position activity during the year was initially reflected as a prior-period adjustment but in fact related to unexpended appropriation activity.

- **National Institutes of Health (NIH).** The NIH, with net outlays of $14 billion, made hundreds of adjustments totaling over $7 billion to current and prior-year accounts before preparing a reliable set of financial statements. While these entries were normal yearend account closing adjustments, many were identified or recorded as late as January or early February 2000. For example, from December 1999 to January 2000, NIH reclassified asset account credit balances of $629 million as liabilities. In addition, auditors identified unrecorded grant expenses of $84 million. Numerous other entries totaling $350 million — some error corrections and others forced adjustments — were made as late as February 2000.

- **Substance Abuse and Mental Health Services Administration (SAMHSA).** The SAMHSA, with net budget outlays of about $2 billion, made over 50 adjustments aggregating over $8 billion before completing its financial statements in February 2000. Many of the adjustments related to errors in prior-year budgetary account balances that had accumulated in the accounting system over time and remained unadjusted (i.e., one-time "catch-up" adjustments).

Reconciliations and account analyses were not conducted throughout the year to detect accounting aberrations.

In our view, the operating divisions' financial process is designed to prepare auditable yearend balances, not to portray accurate financial information for routine management decision-making or for identification of discrepancies or unusual trends. The operating divisions conducted reconciliations and account analyses sporadically, not periodically throughout the year. Because an updated departmental policy emphasizing the need for periodic reconciliations and analyses was not issued until July 29, 1999, this was a systemic problem for most of the year. Compounding these problems were the widespread practices of adjusting financial statement amounts but not the underlying general ledger, using accounts not prescribed by the U.S. Standard General Ledger, and not posting accounts in accordance with prescribed U.S. Standard General Ledger rules.

Reconciliations and account analyses are key internal controls because they bring accounting aberrations to management's attention for resolution. When they are not performed in the normal business cycle, material errors and irregularities will not be promptly detected. The resulting financial statements will be at risk of being inaccurate, unreliable, and unauditable.

Following are examples of problems that occurred because of the lack of reconciliations and analyses:

- The HCFA did not independently verify the Medicare Supplementary Medical Insurance (SMI) and Hospital Insurance (HI) trust fund balances, did not reconcile these accounts at a sufficiently detailed level, and used ineffective methodologies to calculate SMI and HI transfers. As a result, the SMI fund was underfunded by $18 billion and HI was overfunded by $14 billion. The SMI fund lost interest earnings of $237 million and the HI fund realized excess interest earnings of $154 million as a consequence. Although aggregate fund balances with Treasury and investment balances for each trust fund were properly stated in HCFA's FY 1999 financial statements, cash transfers related to the principal to make the individual trust funds whole did not occur until October 1999. Issues relating to interest will require additional action to restore the trust funds to the amount that would have been reflected had such errors not occurred. A corrective action plan to preclude similar problems in the future has been implemented.

- The HCFA did not periodically validate the National Claims History File to ensure the existence and completeness of the data. Due to a breakdown in internal quality controls, the file was missing 100 million Medicare claims amounting to over $13 billion — or more than 25 percent of the processed claims — from June until December 1999. This file, which has since been corrected, is critical to accurately estimate Medicare benefits payable, to prepare the Medicare trustees report, to determine the SMI monthly premiums, to establish managed care rates, to update the diagnostic-related groups for inpatient hospitals, and to develop annual budget projections.

- At ACF, the grant accrual on the initial draft of the financial statements was in error. After researching the fluctuation from the 1998 accrual levels, an audit adjustment of approximately $660 million was necessary.

While corrective action is underway or completed on the above problems, these matters should have been detected during the normal business cycle through routine reconciliation and analysis of accounts.

For FY 1999, the Department implemented an automated, Internet-based financial statement reporting system to produce the HHS financial statements from a compilation of operating division financial statements. Although this is a first step toward implementing a fully integrated and unified accounting system, it is clear from the problems identified that the Department must take steps in the interim to improve accounting procedures and financial reporting processes. In particular, the Department should closely monitor operating division compliance with the recently revised reconciliation policy and emphasize the need to analyze account information in the normal business cycle. Without significant improvement, existing financial systems will

continue to require inordinate resources at yearend to prepare financial statements, will not adequately serve management needs for reliable interim data, and will jeopardize the Department's ability to maintain unqualified opinions on future financial statements.

Recommendations. We recommend that the Assistant Secretary for Management and Budget (ASMB) and operating division Chief Financial Officers (CFO):

- continue the work already begun on producing reliable financial statements on time;
- ensure that accounting staff reconcile and analyze accounts throughout the year, as prescribed by revised departmental policy issued July 29, 1999;
- ensure that interim accounting information is sorted and accumulated in a manner useful to operating division management and for financial reporting purposes — an even more critical need since passage of the Government Performance and Results Act;
- continually assess financial systems for compliance with Federal financial system requirements, Federal accounting standards, and the U.S. Standard General Ledger at the transaction level, and focus these efforts on the generation of financial statements from the general ledger rather than adjunct accounting systems; and
- develop and implement yearend closing procedures that facilitate timely production of financial statements.

2. Medicare Accounts Receivable (Repeat Condition)

We noted major improvement in validating accounts receivable, but inadequate internal controls persist.

Medicare accounts receivable primarily represent overpayments owed by providers to HCFA and funds due from other entities when Medicare is the secondary payer. The HCFA contractors are responsible for reporting and collecting the majority of these receivables — over 81 percent of the outstanding balance at yearend — and the HCFA central office and regional offices manage the remainder.

In FY 1998, we qualified the Departmentwide opinion mainly because Medicare contractors could not support beginning accounts receivable balances, reported incorrect activity and collections, and could not reconcile reported ending balances with subsidiary records. We

reported Medicare accounts receivable as a material internal control weakness because Medicare contractors (1) used rudimentary, single-entry accounting systems that lacked general ledger capabilities for Medicare program activity and (2) reported receivable activity to HCFA based on ad hoc spreadsheets.

The HCFA initiated a major effort in FY 1999 to validate and document accounts receivable. The HCFA and OIG staff, together with two independent public accounting firms, validated receivables at 15 Medicare contractors which accounted for over 80 percent of the contractor receivable balance, the 10 HCFA regional offices, and the HCFA central office. This effort identified over $2 billion in overstated and understated receivables. These receivables included about $1 billion in biweekly advance payments (referred to as periodic interim payments, or PIP) to providers for which claims had already been submitted. Specifically, the validation team found the following problems:

- Contractors did not always follow HCFA policies, and HCFA regional offices maintained inadequate oversight of contractor adherence. About $191 million was found in clerical errors because of inadequate internal controls and oversight. In addition, support could not be found to validate $1.3 billion in receivables, including about $700 million attributable to cases where Medicare was the secondary payer.

- Some contractors reported PIP receivables net of payables due to providers; others reported them on a gross basis. Some contractors did not record estimates for PIP at the end of the period, and others misclassified the amounts recorded. One contractor alone incorrectly included $500 million as a PIP receivable, an error that was identified by HCFA central office controls.

- When receivables were transferred, controls were not in place to notify contractors that regional offices accepted or rejected the transfers. As a result, about $85 million in transferred receivables was erroneously included in the accounting records of both the Medicare contractors and the HCFA regional offices or, in some cases, neither.

Contractors refer receivables to the regional offices when they have exhausted collection efforts, which generally consist of sending three overpayment demand letters to providers. The first request is sent immediately after discovery or determination of the overpayment. The second and third demand letters are mailed at 30-day intervals after the first letter for Medicare Part A and at 45-day intervals for Part B. If the regional office determines that HCFA should take further collection action, the contractor transfers the receivable to that office which, in turn, sends

at least one additional 30-day demand letter to the provider. If the refund is not received within 60 days, the case should be considered for termination or other collection action. For example, the case may be transferred to the central office for referral to the HCFA Office of General Counsel.

The validation team found almost $900 million in outstanding receivables at the regional offices and the central office as of October 1, 1998. This debt was in various stages of collection. For example, $149 million was in litigation or appeal, and $166 million had been forwarded to the Department's debt collection office or the Department of Treasury for cross-servicing. We are most concerned, however, that some $243 million involved bankruptcy cases and $294 million was still pending further debt collection action. Some of this debt was already 6 months old when it was transferred from the contractors and therefore may not have been in compliance with the Debt Collection Improvement Act of 1996. The act requires that any non-tax debt owed to the Federal Government that is 180 days delinquent be referred to the Department of the Treasury for collection. The team also noted that about half of the debt due from institutional providers involved a type of provider with a high incidence of bankruptcy. Timely debt collection becomes even more critical when millions of dollars in overpayments are due from high-credit-risk providers.

As a result of the validation effort, the receivables balance was fairly presented as of the year's end. However, HCFA and the Medicare contractors still do not have adequate internal controls to ensure that future receivables will be properly reflected in their financial reports. Therefore, similar validation procedures will be needed on future receivable activity and balances. Our current review also showed that the lack of an integrated financial management system continued to impair HCFA's and the contractors' ability to adequately support reported accounts receivable activity and balances. The contractors still used ad hoc, single-entry accounting systems, did not accrue liabilities in accordance with generally accepted accounting principles, and did not use proper cutoff procedures.

Moreover, we again found that the HCFA central office did not routinely analyze or monitor receivable balances other than on a very aggregate basis. Because HCFA did not perform a detailed review or analysis of contractor data submissions, it had limited assurance that account balances were accurate and supported by appropriate documentation, and it could not readily identify emerging trends in accounts receivable activity that might require additional management attention. Additionally, HCFA could not readily isolate or identify accounts receivable activity that might have a material impact on the financial statements. For example, HCFA did not perform a detailed analysis throughout FY 1999 to gauge the effect of providers' transitioning to the interim payment and prospective payment systems. Coupled with full implementation of provisions of the 1997 Balanced Budget Act, one contractor's activity ultimately resulted in increased accounts receivable collectively exceeding $1 billion. Some of

these receivables are associated with providers that are now insolvent, have withdrawn from the Medicare program, or have negotiated extended repayment plans.

In addition, we found that:

- one Medicare contractor offset a receivable with a payable, thereby understating the receivable balance by $130 million, and
- another contractor overstated receivable balances by $58 million because it did not account for all claim and payment activity.

Recommendation. We recommend that ASMB continue monitoring HCFA's development of an integrated Medicare financial management system which includes a double-entry general ledger. Detailed recommendations are outlined in the HCFA audit report.

3. Medicare Electronic Data Processing (Repeat Condition)

Year 2000 compliance efforts delayed corrective action on prior EDP internal control deficiencies.

The HCFA relies on extensive electronic data processing (EDP) operations at both its central office and the Medicare contractors to administer the Medicare program and to process and account for Medicare expenditures. Internal controls over these operations are essential to ensure the integrity, confidentiality, and reliability of critical data while reducing the risk of errors, fraud, and other illegal acts. Although HCFA fully recognized the importance of these controls, its FY 1999 resources were devoted in large part to addressing Year 2000 readiness issues. As a consequence, not all prior-year EDP findings were resolved.

The HCFA central office systems maintain administrative data, such as Medicare enrollment, eligibility, and paid claims data, and process all payments for managed care. In FY 1999, managed care payments totaled about $37 billion.

The Medicare contractors, each with its own data processing system, use one of several "shared" systems to process and pay fee-for-service claims. These shared systems generally interface with the Common Working File (CWF) to obtain authorization to pay claims and to coordinate Medicare Part A and Part B benefits. The CWF uses seven distributed databases provided by contractors known as CWF host sites. The shared systems and the CWF are maintained by contractors referred to as system maintainers. This network accounted for and processed $169.5 billion in Medicare expenditures during FY 1999.

Our review of EDP internal controls covered general and application controls. EDP general controls involve the entity-wide security program, access controls, application development and program change controls, segregation of duties, operating system software, and service continuity. General controls affect the integrity of all applications operating within a single data processing facility and are critical to ensuring the reliability, confidentiality, and availability of HCFA data. Application controls involve input, processing, and output controls related to specific EDP applications.

We found numerous EDP general control weaknesses at the HCFA central office and the Medicare contractors, as well as application control weaknesses at the contractors' shared systems. Such weaknesses do not effectively prevent (1) unauthorized access to and disclosure of sensitive information, (2) malicious changes that could interrupt data processing or destroy data files, (3) improper Medicare payments, or (4) disruption of critical operations. Further, weaknesses in HCFA's entity-wide security structure do not ensure that EDP controls are adequate and operating effectively. As noted below, two of these weaknesses were considered material.

- **HCFA central office.** The HCFA central office has begun to implement several actions to improve controls, such as planning for additional security software to restrict access to sensitive Medicare databases. However, because these actions had not been completed as of the year's end, some previously reported weaknesses in general and application controls remained unchanged. Most problematic was the deficiency in mainframe database access controls, which was also reported as a material control weakness in both FYs 1997 and 1998. Additional problems were noted this year in entity-wide security and operating system controls.

- **Medicare contractors.** Our reviews at a sample of 14 Medicare contractors included reviews of general controls at 4 contractors, general and application controls at 3 contractors, and change controls at 3 contractors, as well as reviews of prior-year findings at 4 contractors. While our follow-up work found that many of the prior-year findings had been resolved, problems continued in the Fiscal Intermediary Standard System (FISS).

  The material weakness in the FISS remained unchanged from that reported in FYs 1997 and 1998; that is, Medicare data centers had full access to the FISS source code and could make local changes to FISS programs. Although HCFA required contractors to restrict local changes to emergency situations, the local changes were still not subjected to the same controls that exist in the standard FISS change process.

For the Multi-Carrier System, on the other hand, the previous finding that each individual carrier could deactivate HCFA-mandated edits was resolved.

Recommendation. We recommend that ASMB continue overseeing HCFA's implementation of corrective actions to address EDP control weaknesses at Medicare contractor sites and the HCFA central office. Detailed recommendations are contained in the HCFA audit report.

REPORTABLE CONDITIONS

1. HCFA Regional Office Oversight of Medicare (New Condition)

During FY 1999 and early FY 2000, HCFA began a series of initiatives to improve oversight of the Medicare claim processing contractors. Among these initiatives is the use of independent contractors to review (1) contractors' cost report quality review programs and enhanced protocols and (2) more than 20 of the major contractors' systems and processes. While these are excellent first measures, inappropriate claim payments continued at a high level, and OIG investigations showed ongoing problems with Medicare contractor activities.

Regional office oversight was not sufficient to ensure that financial data provided by contractors were reliable, accurate, and complete. For example, regional offices did not:

- provide sufficient coverage of contractor performance evaluations or conduct sufficient on-site reviews of the completeness and accuracy of contractors' provider cost report information and Medicare secondary payer operations;
- adequately monitor contractor reports, specifically the Statements of Financial Position (HCFA 750), Status of Accounts Receivable (HCFA 751), and Monthly Contractor Financial Report (HCFA 1522);
- adequately verify the completeness and accuracy of the accounts receivable tracking reports, the Provider Overpayment Report (POR) and the Physician Supplier Overpayment Report (PSOR); or
- timely implement HCFA central office directives.

Recommendation. We recommend that ASMB oversee HCFA's efforts to improve regional office oversight of the Medicare program. Specific recommendations to HCFA are covered in a separate report.

2. Medicaid Estimated Improper Payments (Repeat Condition)

The Medicaid program, enacted in 1965 under Title XIX of the Social Security Act, is a grant-in-aid medical assistance program largely for the poor, the disabled, and persons with developmental disabilities requiring long-term care. Funded by Federal and State dollars, the program is administered by HCFA in partnership with the States via approved State plans. Under these plans, States reimburse providers for medical assistance to eligible individuals, who numbered more than 33 million in 1999. In FY 1999, Federal and State Medicaid outlays totaled about $180.8 billion; Federal expenses were $109 billion.

We found that HCFA still lacked a methodology to estimate the extent of improper Medicaid payments on a national level. For the last 4 years, the OIG reviewed a statistically valid sample of Medicare claims and estimated the extent of payments that did not comply with laws and regulations. The majority of errors fell into four broad categories: insufficient or no documentation, lack of medical necessity, incorrect coding, and noncovered services. This information helped HCFA to monitor and reduce improper Medicare payments. Because HCFA has not established a similar methodology for the Medicaid program, it cannot reach conclusions on the extent of Medicaid payment errors. We recognize that Medicaid is a State-administered program, so estimates of improper payments will require the cooperation of States.

We noted some recent progress in this area. In FY 1999, HCFA established a departmental workgroup to review the Medicaid error rate issue. Also, HCFA requested $5 million in the FY 2001 budget for grants to a sample of States to begin developing this information.

Recommendation. We recommend that ASMB and HCFA work with the States to develop procedures and implement a methodology for determining the extent of improper Medicaid payments.

3. Departmental Electronic Data Processing (Repeat Condition)

The following summarizes some of the systemic EDP control weaknesses identified in audits of operating division financial statements and service organization operations. Other weaknesses are reported in the individual reports on these entities.

- **Division of Financial Operations (DFO) Financial Management Systems.** The Program Support Center's DFO provides financial management and accounting services to certain operating divisions. To provide the services, the DFO uses several automated systems. While the DFO continues to strengthen controls over these systems, further improvements are needed.

- The DFO had access control weaknesses associated with its security software, which was intended to protect the financial management systems' production data and programs. Some users had excessive access privileges inconsistent with their job responsibilities.

- The source code for production programs was maintained in a single library that was accessible to all application programmers.

- The DFO did not adequately separate the duties of its contract programmers. The programmers could process transactions and create or change authorized functions within the financial management systems. They did in fact process approximately 100 transactions during FY 1999.

❑ **NIH.** The NIH policies and procedures related to requests for systems access need to be strengthened. Application programmers had full access to the development, testing, and production environment. The NIH management has begun developing draft policies and procedures to enhance the logical access and program change controls. Without such procedures, management cannot ensure that internal controls over access to applications are consistently applied or that controls over production program and data integrity are not compromised.

❑ **Food and Drug Administration (FDA).** In FY 1998, FDA had several findings under each of the six major categories of general controls. Although FDA resolved many of these findings, some were still outstanding this year. When viewed in the aggregate, these exceptions constituted a reportable condition. Areas that still need improvement include the security program, access controls, software change controls, system software, separation of duties, and service continuity. Similar to the DFO, FDA had an excessive number of users with privileges to affect system operations and critical files.

Recommendation. We recommend that ASMB oversee the efforts of the operating divisions and service organizations to improve system access controls, application development and program change controls, and service continuity plans. Specific recommendations are covered in the separate reports.

4. Property, Plant, and Equipment (Repeat Condition)

In FY 1998, we reported that improvements in accounting for and controlling property, plant, and equipment were needed at NIH and FDA. Improvements are still needed, as noted below.

- **NIH.** We found that NIH posted depreciation expenses in whole-year increments only. As a result, accumulated depreciation was understated by $8.4 million for 68 buildings and was overstated by $5.6 million for 19 buildings. One additional building was depreciated beyond its original cost by $612,500.

- **FDA.** Although FDA improved its Property Management Information System, we still noted problems in tracking property transfers and maintaining supporting documentation.

Recommendation. We recommend that ASMB oversee the implementation of the corrective actions being taken by NIH and FDA. Specific recommendations are provided in separate audit reports.

OTHER MATTERS

FMFIA Reporting

As part of our audit, we also obtained an understanding of management's process for evaluating and reporting on internal control and accounting systems, as required by the Federal Managers' Financial Integrity Act (FMFIA), and compared the material weaknesses reported in the HHS FY 1999 FMFIA report relating to the financial statements under audit with the material weaknesses noted in our report on internal controls. Under OMB guidelines for FMFIA reporting, HHS reports as a material weakness any deficiency that the Secretary determines is significant enough to be disclosed outside the agency. This designation requires HHS management to judge the relative risk and significance of deficiencies. In making this judgment, HHS management pays particular attention to the views of the HHS Inspector General. The HHS management agrees with the HHS Inspector General in reporting to the President and the Congress the three material weaknesses described in this report.

Medicare National Error Rate

While our previous reports included the Medicare national error rate in the "Report on Compliance With Laws and Regulations" section, OMB, the General Accounting Office, and other Federal agencies have differing views on how to properly report national error rates. Development of such error rates is an emerging area, and OMB is developing consistent

reporting requirements. Until we receive clarification, we are reporting the Medicare error rate as "Other Matters."

At HCFA's request, we developed a national error rate of the extent of improper Medicare fee-for-service payments for FY 1999. As discussed in detail in our separate report (CIN: A-17-99-01999), and based on our statistically valid sample, we estimate that improper Medicare benefit payments made during FY 1999 totaled $13.5 billion, or about 7.97 percent of the $169.5 billion in processed fee-for-service payments reported by HCFA. This year's error rate is about $1 billion more than the FY 1998 estimate of $12.6 billion, $6.8 billion less than the FY 1997 estimate of $20.3 billion, and $9.7 billion less than the FY 1996 estimate of $23.2 billion. While this year's estimate is higher than last year's, we cannot conclude that the current error rate is statistically different. The increase may be due to sampling variability; that is, selecting different claims with different dollar values and errors will inevitably produce a different estimate of improper payments.

These improper payments, as in past years, could range from inadvertent mistakes to outright fraud and abuse. We cannot quantify what portion of the error rate is attributable to fraud. The overwhelming majority (92 percent) of these improper payments were detected through medical record reviews coordinated by the OIG. When these claims were submitted for payment to Medicare contractors, they contained no visible errors. Although HCFA has made substantial progress since FY 1996 in reducing improper payments in the Medicare program, continued efforts are needed.

STATUS OF PRIOR-YEAR INTERNAL CONTROL WEAKNESSES

During FY 1999, HHS and its operating divisions substantially completed corrective actions on two prior-year reportable conditions, as discussed below:

Departmental Accounts Payable

This year HHS substantially resolved the previously reported departmental deficiencies in controls over accounts payable. However, accounts payable problems remain a reportable condition at NIH and are so reported in the auditor's report on the NIH financial statements. Problems with HCFA's payables are addressed in "Financial Systems and Reporting" (material weakness No. 1) of this report because they no longer merit separate reporting.

Estimating Losses From Pending Litigation

In FY 1998, we reported that management at several operating divisions did not assess the likelihood of losses from pending claims and lawsuits. Federal accounting standards require

agency management to determine whether it is probable that a legal claim will end in a loss and, if it is estimable, to recognize an expense and a liability for the full amount of the expected loss.

In November 1998, HHS issued final guidance to the operating divisions directing that management obtain from counsel an assessment of the likelihood that lawsuits will result in losses. If a loss is probable and the amount is estimable, management is to record that amount in its accounting records. We consider this condition to be substantially resolved.

REPORT ON COMPLIANCE WITH LAWS AND REGULATIONS

We conducted our audit in accordance with generally accepted auditing standards; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and OMB Bulletin 98-08, *Audit Requirements for Federal Financial Statements,* as amended. These standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements referred to above are free of material misstatement.

The HHS management is responsible for complying with applicable laws and regulations. As part of obtaining reasonable assurance about whether the HHS financial statements are free of material misstatement, we performed tests of management compliance with certain provisions of laws and regulations, noncompliance with which could have a direct and material effect on the determination of financial statement amounts, and with certain other laws and regulations specified in OMB Bulletin 98-08, as amended, including the requirements referred to in the Federal Financial Management Improvement Act (FFMIA) of 1996.

The results of our tests of compliance with laws and regulations, exclusive of FFMIA, disclosed no instances of noncompliance required to be reported under *Government Auditing Standards* and OMB Bulletin 98-08, as amended.

Under FFMIA, we are required to report whether HHS financial management systems substantially comply with Federal financial management systems requirements, Federal accounting standards, and the United States Government Standard General Ledger at the transaction level. Therefore, we performed tests of compliance using the FFMIA implementation guidance included in
Appendix D of OMB Bulletin 98-08, as amended. The results of our tests disclosed instances in which HHS financial management systems did not substantially comply with certain requirements. The following instances of noncompliance were identified:

- The accounting systems used by HHS and the operating divisions were not adequate to prepare reliable, timely financial statements. Instead, a manually intensive and error-prone process was used. These weaknesses prevented the Department from preparing reliable financial statements from the general ledger in a timely manner.

- The HCFA did not have an integrated accounting system to capture expenditures at the Medicare contractor level. This means that for most dollars appropriated to the Department, management depended on ad hoc, nonstandard accounting systems used by the Medicare contractors.

- The HCFA central office and Medicare contractor access and application control weaknesses were significant departures from requirements in OMB Circulars A-127, *Financial Management Systems*, and A-130, *Management of Federal Information Resources*.

The HHS CFO prepared a 5-year plan to address FFMIA and other financial management issues. Although certain milestone dates have passed, we recognize that the plan will require periodic updating to reflect changed priorities and available resources.

Although we performed tests of the Department's compliance with certain provisions of these laws and regulations, our objective was not to provide an opinion on overall compliance with such provisions. Accordingly, we do not express such an opinion.

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Comments from HHS, which are included as appendix II, have been incorporated in this report where appropriate. We appreciate the cooperation and assistance of HHS staff during this audit.

Additionally, we would like to acknowledge the significant contributions made by the staff of the General Accounting Office.

June Gibbs Brown
Inspector General
Department of Health and Human Services

February 25, 2000
CIN: A-17-99-00002

FISCAL YEAR 1999 CFO REPORTS ON HHS OPERATING DIVISIONS AND SERVICE ORGANIZATIONS

Nine separate financial statement audits of HHS operating divisions were conducted in FY 1999:

- Administration for Children and Families *(CIN: A-17-99-00003)*
- Centers for Disease Control and Prevention *(CIN: A-17-99-00013)*
- Food and Drug Administration *(CIN: A-17-99-00011)*
- Health Care Financing Administration *(CIN: A-17-00-00500)*
- Health Resources and Services Administration *(CIN: A-17-99-00005)*
- Indian Health Service *(CIN: A-17-99-00006)*
- National Institutes of Health *(CIN: A-17-99-00012)*
- Program Support Center *(CIN: A-17-99-00007)*
- Substance Abuse and Mental Health Services Administration *(CIN: A-17-99-00004)*

Four Statement on Auditing Standards 70 examinations were conducted:

- Center for Information Technology, NIH *(CIN: A-17-99-00015)*
- Central Payroll and Personnel System, PSC *(CIN: A-17-99-00009)*
- Division of Financial Operations, PSC *(CIN: A-17-99-00008)*
- Payment Management System, PSC *(CIN: A-17-99-00014)*

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

FEB 25 2000

June Gibbs Brown
Inspector General
U.S. Department of Health and Human Services
Washington, DC 20201

Dear Inspector General Brown:

This letter responds to the Office of Inspector General opinion of the FY 1999 audited financial statements of the U.S. Department of Health and Human Services. We concur with your findings and recommendations.

We are tremendously pleased that your report reflects an unqualified, or "clean", audit opinion for the Department for the first time ever. Through our joint efforts, we were able to achieve our goal of both a clean and, for the second year, timely Departmental financial statement audit.

We also acknowledge that significant internal control weaknesses remain. We can now focus our attention on improving our financial systems to resolve these material weaknesses and we are already directing our efforts in that direction.

I would like to thank your office for its continuing professionalism during the course of the audit as they worked in conjunction with my office to address complex financial accounting issues.

Sincerely,

John J. Callahan
Assistant Secretary for Management and Budget/
Chief Financial Officer